

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/15/2010
FORM APPROVED
OMB NO. 0938-0391

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|--|---|--|--|--|--|--|----------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 29C0001059 | | (X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____ | | (X3) DATE SURVEY COMPLETED 11/17/2010 | |
| NAME OF PROVIDER OR SUPPLIER AMBULATORY SURGICAL CENTER OF SOUTHERN NEVADA | | | | STREET ADDRESS, CITY, STATE, ZIP CODE 3820 S HUALAPAI WAY #100 LAS VEGAS, NV 89147 | | | |
| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | | | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | | (X5) COMPLETION DATE |
| Q 000 | INITIAL COMMENTS This Statement of Deficiencies was generated as a result of a Medicare Recertification Survey conducted at your facility 11/15/10 and 11/17/10, in accordance with 42 Code of Federal Regulations (CFR) 416, Requirements for Ambulatory Surgery Centers. Twenty clinical records were reviewed. The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state or local laws. | | | Q 000 | | | |
| Q 225 | The following deficiencies were identified: 416.50(a)(3)(i), (v), (vi), (vii) SUBMISSION AND INVESTIGATION OF GRIEVANCES (i) The ASC must establish a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's written or verbal grievance to the ASC. (v) The grievance process must specify timeframes for review of the grievance and the provisions of a response. (vi) The ASC, in responding to the grievance, must investigate all grievances made by a patient or the patient's representative regarding treatment or care that is (or fails to be) furnished. (vii) The ASC must document how the grievance was addressed, as well as provide the patient with written notice of its decision. The decision must contain the name of an ASC contact person, the steps taken to investigate the grievance, the results of the grievance process, and the date the grievance process was completed. | | | Q 225 | | | |
| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | | | | TITLE | | (X6) DATE | |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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| Q 225 | Continued From page 1 This STANDARD is not met as evidenced by: Based on interview and policy and procedure review, the facility failed to ensure a grievance procedure for documenting the existence, submission, investigation, and disposition of a patient's grievance to the center. Findings include: In 11/17/10, the facility's policies and procedures were reviewed. The grievance policy did not address the existence, investigation, or disposition of patients' grievances. On 11/17/10, the lead technician was interviewed. She reported there was no log or tracking for patient grievances. | | | Q 225 | | | |
| Q 232 | 416.50(c)(2) SAFETY [The patient has the right to -] Receive care in a safe setting This STANDARD is not met as evidenced by: Based on observation and staff interview, the facility failed to provide a safe environment. Findings include: On 11/17/10, the following observations were made: 1) The door to the discharge waiting room was propped open for more than 20 minutes. The door opened to the outside parking lot. Staff did not continuously monitor the opened door. | | | Q 232 | | | |

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| Q 232 | <p>Continued From page 2</p> <p>During an interview with the Lead Technician, it was reported that the nurses sometimes prop open the door for a few minutes when patients are discharged but normally lock the door by closing it following the discharge.</p> <p>2) The door to the power room was propped open. The room was identified by a sign that read "Backup Power." Access to the generator was blocked by a housekeeping cart, a large trash can and three cans of partially used paint. In addition, there were three soiled towels found on the floor of the room. During an interview with the Lead Technician, she reported that the generator room was not to be blocked and that it was not their practice to use the room for storage.</p> <p>3) A container labeled "Neutral Cleaner" was found on top of the water heater in the housekeeping closet.</p> <p>4) The patient food refrigerator contained multiple containers of opened juice. The containers were not labeled with the dates they were opened. The freezer contained food substances that could not be identified as to what type of food they were in the freezer. Staff were unable to identify the food substances when interviewed.</p> <p>5) The medication refrigerator in the medication room contained a small freezer compartment. The freezer compartment had a buildup of over one inch of ice inside and outside the compartment. The ice outside the compartment was within several inches of refrigerated medications stored on a shelf. During an interview on 11/17/10, a Registered Nurse agreed the freezer needed to be cleared of the frozen ice.</p> | Q 232 | | | | | |

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| Q 232 | Continued From page 3 6) The medication refrigerator in the medication room contained four control vials in a Biohazard bag that was being used as a baggie (plastic bag). The vials contained a red fluid and the bag contained a small amount of red fluid, which may have leaked from one of the vials. No leakage was noted outside of the bag. All four vials had expired and were labeled with an expiration date of 2/16/10. During an interview on 11/17/10, a Registered Nurse reported the vials were specimen containers that should not have been stored in the medication refrigerator. She reported that the vials were normally kept in the biohazard refrigerator in the biohazard room. | | | Q 232 | | | |
| Q 241 | <p>416.51(a) SANITARY ENVIRONMENT</p> <p>The ASC must provide a functional and sanitary environment for the provision of surgical services by adhering to professionally acceptable standards of practice.</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, the facility failed to ensure documentation was completed for the change of solution used for high level disinfection.</p> <p>Findings include:</p> <p>On 11/15/10, the high level disinfection processing was observed. Rapicide, a high level disinfectant and sterilant, was being used for high level disinfection. A white board in the re-processing room was used to record the dates the solutions needed to be changed. On the white board, it was documented the Rapicide would need to be changed on 11/24/10. Interview with the sterile processing technician revealed the</p> | | | Q 241 | | | |

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| Q 241 | Continued From page 4 Rapicide solution was required to be changed every 28 days. Review of the log revealed the last entry for changing the Rapicide solution was 9/30/10. Interview with the sterile processing technician who changed the solution revealed the solution was changed on 10/28/10, but that he had forgotten to document the change of solution in the log. | Q 241 | | | |